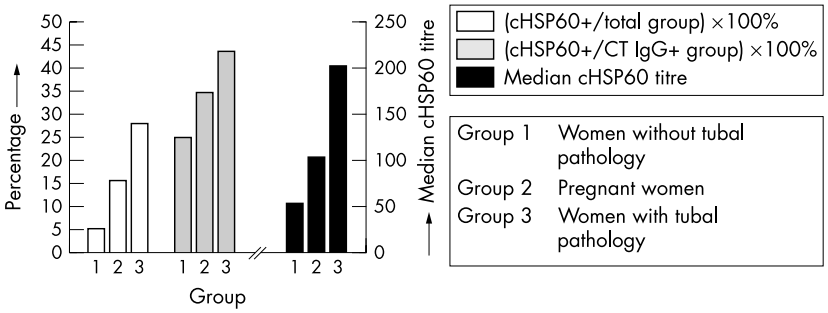

Figure 1 *Chlamydia trachomatis* IgG and cHSP60 antibody responses in Dutch white women with different degrees of tubal pathology.

chlamydial and human HSP60 results in autoimmune mediated fallopian tube damage. Owing to the significance of the possible association of the response to cHSP60 and progressive disease, a commercially produced assay that employs defined cHSP60 epitopes should allow for the comparison of results obtained in different laboratories, as well as forward the use of cHSP60 as a diagnostic tool if the assay proves to be relevant in predicting pathology or clinical outcome of a urogenital chlamydial infection.

This study evaluated a recently introduced commercially available cHSP60 serological assay and determined the anti-cHSP60 responses in three gynaecologically well defined groups of women.

Group 1 consisted of women without tubal pathology as assessed by either hysterosalpingography or laparoscopy (n = 21), group 2 consisted of pregnant women (unknown tubal status, proved fertility; n = 86), and group 3 consisted of women with confirmed (based on hysterosalpingography or laparoscopy) tubal pathology (n = 11). *C trachomatis* positivity was assessed previously using one of the following serological assays: microimmunofluorescence (MIF) (BioMérieux's Hertogenbosch, Netherlands), BAG Chlamydia EIA (Biologische Analysensystem GmbH, Lich, Germany) and the CT-pELISA (Medac, Wedel, Germany). The study groups and techniques were described previously.[2 3] The cHSP60 assay (Medac, Wedel, Germany) was performed according to the manufacturer's instructions.

Results are shown in figure 1. *C trachomatis* IgG positivity was previously determined to be 19% for group 1, 40% for group 2, and 64% for group 3, showing the expected clear difference in IgG seroprevalence between women with and without procedure confirmed tubal pathology, while an intermediate prevalence observed in pregnant women. The same pattern but with lesser incidence was observed in the anti-cHSP60 responses being 4.8%, 16%, and 27%, for groups 1–3, respectively (χ^2 test for trend: $\chi^2 = 3.1$, p = 0.079, group 1 *v* group 3: p = 0.096, OR 10.6). The incidences of anti-cHSP60 were increased in the CT IgG positive subgroups to 25%, 35%, and 43%, for groups 1–3, respectively (see lower panel in fig 1), while only 3.8% anti-cHSP60 titres were observed in the *C trachomatis* IgG negative subgroups, all in subgroup 2 (unknown tubal status, proved fertility). This indicates that the concordance between CT IgG and cHSP60 positivity is high, almost 90%; however, clearly a different subgroup of women is identified by the cHSP60 assay since only 40% of the *C trachomatis* IgG positive women has a cHSP60 response (measurement of agreement: kappa 0.371). Finally, the median cHSP60 titres increased from groups 1–3: 50, 100, and 200, respectively, suggesting an association between the level of cHSP60 response and tubal pathology.

As far as we know this is the first study evaluating the commercially available cHSP60 assay in women with different degrees of tubal pathology. Two abstracts were published in the ISSTDR meeting Vienna, Austria in 2002[4 5] on cHSP60 antibodies in women with pelvic inflammatory disease (85% in patients with *C trachomatis* positive swabs and patients with occluded tubes, 20% in blood donors) and in women with open or occluded fallopian tubes (31% and 70% respectively).

The standardisation provided through this new commercially available assay will potentially enhance the comparability of cHSP60 results between laboratories. The results presented here, although obtained in small but well defined groups, look suggestively promising. Indeed, power calculations (alpha = 0.5, beta = 0.1) show that doubling (1.7 times) the size of the (sub)groups would results in significant p values instead of clear trends. However, further studies are needed in larger groups with different degrees of pathology because of *C trachomatis* infections to further determine the diagnostic, prognostic, and clinical relevance of this new assay.

Contributors

CJB, drafting of the manuscript, involved in the initial collection of the cohort, collection of the clinical data, and laboratory serology analyses for IgG *C trachomatis*, corresponding author; JS, *C trachomatis* heat shock protein 60 serology, data management, critically reading the manuscript; PMO, providing the setting for and supervision of all serology assays performed to determine *C trachomatis* IgG presence, critically reading the manuscript; JBT, supervision of the data collection, critically reading the manuscript; PJD, providing setting and logistics for cohort collection, supervision of the clinical data collection, critically reading the manuscript; ASP, providing the setting for JS to perform the *C trachomatis* work, critically reading the manuscript; SAM, principal investigator for this manuscript and the *Chlamydia trachomatis* research line, drafting of the manuscript, data analyses, and overall supervision.

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References

1 **Morré SA**, Munk C, Persson K, *et al*. Comparison of three commercially available peptide-based immunoglobulin G (IgG) and IgA assays to microimmunofluorescence assay for detection of Chlamydia trachomatis antibodies. *J Clin Microbiol* 2002;**40**:584–7.
2 **Bax CJ**, Mutsaers JA, Jansen CL, *et al*. Comparison of serological assays for detection of Chlamydia trachomatis antibodies in different groups of obstetrical and gynecological patients. *Clin Diagn Lab Immunol* 2003;**10**:174–6.
3 **Bax CJ**, Oostvogel PM, Mutsaers JA, *et al*. Clinical characteristics of Chlamydia trachomatis infections in a general outpatient department of obstetrics and gynaecology in the Netherlands. *Sex Transm Infect* 2002;**78**:E6.
4 **Petersen EE**, Clad A, Pichlmeier U, *et al*. The extended Chlamydia trachomatis diagnosis in patients with pelvic inflammatory disease—a better approach for the diagnosis of upper genital tract infections. *Int J STD AIDS* 2002;**13**(Suppl 1):29.
5 **Clad A**, Petersen EE, Dettlaff S. Antibodies to Chlamydia trachomatis heat shock protein 60 (CHSP60) and Chlamydia trachomatis major outer membrane protein (MOMP) in women with different tubal status. *Int J STD AIDS* 2002;**13**(Suppl 1):28.

The prevalence of excessive alcohol consumption and the acceptability of brief advice in a sexual health clinic: cross sectional survey

Excessive alcohol consumption has been implicated in unsafe sex and the spread of sexually transmitted infections.[1] Cross sectional surveys in sexual health clinics have shown that most patients drink alcohol regularly,[2] but the proportion misusing alcohol has not been reported. Brief interventions for alcohol misuse have been shown to be beneficial across a range of medical settings,[3] but their use in sexual health clinics has not been explored. We therefore examined the acceptability of offering brief advice to people identified as misusing alcohol in a sexual health clinic.

Two doctors (PCL, CB) set out to recruit consecutive attendees at walk-in clinics at the Jefferiss Wing Centre for Sexual Health at St Mary's Hospital in London over a 3 month period. Consenting patients were interviewed using the Paddington Alcohol Test (PAT).[4] Those drinking excessively were offered a self help leaflet, ''Think about Drink,'' and/or an appointment with an alcohol health worker (AHW). Acceptance of brief intervention was noted, and AHW records examined to find

out whether patients attended their appointment.

Three hundred and five people were invited to take part in the study, of whom 302 (99%) agreed. The sample comprised 210 women and 92 men, of whom 284 were heterosexual and 18 bisexual or homosexual. In all, 253 (84%) reported drinking alcohol and 98 (32%) were drinking excessively according to PAT. Men were more likely to be consuming excessive alcohol than women (46% compared to 27%, $\chi^2 = 9.8$, $p = 0.001$). Thirty nine (39.8%) of those consuming excessive alcohol stated that their attendance in the clinic was related to alcohol. The most commonly stated reasons for this were either that being drunk led to sexual contact which would not otherwise have taken place or that alcohol consumption had resulted in sex without use of a condom.

Brief written advice was accepted by 91 (93%) of those drinking excessively. A further 30 (31%) accepted an appointment with an AHW. Those who stated they would accept an appointment with an AHW drank a median of 13.5 units of alcohol per session compared to 10 units among those who declined an appointment ($Z = -2.5$, $p = 0.01$), but no other differences were found. Subsequent examination of hospital records revealed that only one of those given an appointment actually attended it.

Levels of alcohol misuse in this sample are higher than in the general population and in medical settings like accident and emergency departments where there has been far greater discussion of the importance of this problem.[5] Over 90% of those drinking excessively were willing to accept written advice, an intervention that may reduce levels of alcohol misuse.[6] However, less than a third were willing to accept an appointment with an AHW and only one person attended the appointment. The likelihood of someone accepting an appointment with an AHW is increased by ensuring that it is delivered at a time and place of convenience; when offered in this way it is usually accepted.[5]

We believe that providing even brief interventions for alcohol misuse in sexual health clinics would not be straightforward. Further development of interventions that are acceptable to patients is needed and evidence that interventions are effective and impact on sexual health outcomes may be needed if screening and intervention are considered worth the initial investment that would be required.

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Contributors

MJC, PL, and LG designed the study; PL and CB collected the data; MJC and PL analysed the data; all authors contributed to writing the paper and reviewed the final version of the manuscript; MJC is guarantor.

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References

1 **Strategy Unit**. *Alcohol harm reduction project: interim analytical report*. London: Cabinet Office, 2003:79–80.
2 **Bagauley SDK**. Recreational drug use by GUM clinic attendees. *Sex Transm Infect* 2002;**78**:310.
3 **Wilk AJ**, Jensen NM, Havighurst. Meta-analysis of randomised control trials addressing brief interventions in heavy drinkers. *J Gen Intern Med* 1997;**12**:274–83.
4 **Hodgson R**, Alwyn T, John B, *et al*. The fast alcohol screening test. *Alcohol Alcoholism* 2002;**37**:61–6.
5 **Wright S**, Moran L, Meyrick M, *et al*. Intervention by an alcohol health worker in an accident and emergency department. *Alcohol Alcoholism* 1998;**33**:651–6.
6 **Spivak K**, Sanchezcraig M, Davila R. Assisting problem drinkers to change on their own—effect of specific and non-specific advice. *Addiction* 1994;**89**:1135–42.

Resolution of lymphocytic interstitial pneumonitis in an HIV infected adult after treatment with HAART

The optimal therapy for lymphocytic interstitial pneumonitis (LIP) in HIV infected adults is currently unknown. We describe an HIV patient with LIP who improved with protease inhibitor based highly active antiretroviral therapy (HAART) without concurrent corticosteroids.

Case report

A 52 year old heterosexual African-American man, diagnosed with HIV infection 3 years before presentation, was hospitalised for an evaluation of an abnormal chest radiograph obtained during medical screening. His CD4+ lymphocyte count was 198 cells $\times 10^6$/l, and plasma HIV-1 RNA level >290 000 copies/ml. He denied all symptoms, including cough, shortness of breath, chest pain, fever, and weight loss.

On admission, vital signs included temperature 37.1℃, respiratory rate 16 breaths/minute, and room air oxygen saturation 94%. Complete physical examination was unremarkable, including pulmonary examination. Laboratory data included white blood cell count 5800 $\times 10^6$/l. Room air arterial blood gas: pH, 7.42; pCO_2, 38 mm Hg; pO_2, 70 mm Hg; A-a gradient 33 mm Hg. Chest high resolution computed tomography (HRCT) scan revealed diffuse micronodules and right lower lobe consolidation, without pleural effusions or intrathoracic lymphadenopathy (fig 1A). Pulmonary function tests (PFTs) revealed a mild restrictive ventilatory defect and a moderately reduced diffusing capacity (table 1).

Tuberculosis was considered; multiple induced sputum smears and cultures were negative for acid fast bacilli. Fibreoptic bronchoscopy was performed; bronchoalveolar lavage and transbronchial biopsy smears and cultures were negative for bacteria, fungi, and acid fast bacilli. Mature lymphoid infiltration and proliferation were seen and associated with germinal centre formation and focal invasion and destruction of the bronchial epithelium (fig 2). The histological features are characteristic of LIP.[1]

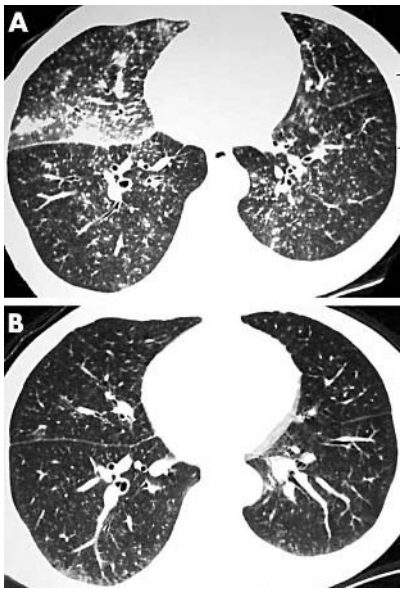

Figure 1 (A) High resolution computed tomography (HRCT) scan of the chest showing diffuse random nodules with mild septal thickening and right lower lobe consolidation. (B) HRCT scan of the chest after 3 months of HAART demonstrating marked improvement in nodules, septal thickening, and consolidation. Note: The images are from comparable but not identical levels of the lung.

Treatment with corticosteroids and/or HAART was considered. Since the patient met criteria for initiating HAART,[2] he was started on tenofovir disoproxil fumarate, lamivudine, and lopinavir plus ritonavir. Because he was asymptomatic, concurrent corticosteroids were withheld. After 1 month, his CD4+ lymphocyte count increased to 392 cells $\times 10^6$/l with a concurrent 100-fold decrease in viral load, now currently undetectable. Repeat PFTs after 2 months on HAART showed significant improvement in all measurements (table 1). Follow up HRCT after 3 months on HAART demonstrated marked improvement (fig 1B). At present, the patient remains on HAART without evidence of pulmonary disease.

Comment

LIP is a common complication of HIV infection in children but is uncommon in adults. Although the clinical, radiographic, and histopathological characteristics of LIP are relatively well described, the aetiology and pathogenesis remain unknown and the optimal treatment is undefined.[3] We report a case of a patient with HIV and LIP who improved with HAART alone.

Viral replication and ongoing reaction against lung specific viral strains have been implicated as factors in the aetiology and pathogenesis of LIP.[4 5] Mice infected with the LP-BM5 retrovirus (an inducer of murine AIDS) developed interstitial pneumonitis which responded to zidovudine. Treatment resulted in a dose dependent reduction of viral RNA in the lungs of infected, treated mice when compared with untreated mice. Lung biopsies from HIV infected patients with LIP demonstrated oligoclonal expansion